NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

1820 RANDOLPH RD SE Φ P.O. BOX 27198
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE

GENERAL

EMPLOYER (NAME & ADDRESS, INCL ZIP)
CITY OF SANTA FE
PO BOX 909
SANTA FE, NM 87504

SIC CODE

EMPLOYER FEIN
85-6000168

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION
NM

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #
(505) 955-6517

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO.)
CITY OF SANTA FE
PO BOX 909
SANTA FE, NM 87504
(505) 955-6407

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☒ SELF INSURED

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)
CCMSI
PO BOX 30870
ALBUQUERQUE, NM 87190
(800) 635-0679

CARRIER FEIN
85-6000168

POLICY / SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE
NM

ADDRESS (INCLUDE ZIP)

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARTIAL STATUS
☐ UNMARRIED SINGLE/DIVORCE
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION / JOB TITLE

EMPLOYMENT STATUS
PERM

PHONE
( ) -

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE

PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME / PHONE NUMBER
( ) -

TYPE OF INJURY / ILLNESS

PART OF BODY AFFECTED

DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?
☐ YES ☐ NO

TYPE OF INJURY / ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS / ADNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE EMPLOYEE ILL.

CAUSE OF INJURY CODE

DATE RETURNED TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN / HEALTH CARE PROVIDER & NAME & ADDRESS)
CONCENTRA MEDICAL CENTER
720 ST MICHAELS DRIVE
SANTA FE, NM 87505

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
0 ☐ NO MEDICAL TREATMENT
1 ☐ MINOR: BY EMPLOYER
2 ☒ MINOR CLINIC/HOSPITAL
3 ☐ EMERGENCY CARE
4 ☐ HOSPITALIZED > 24 HRS.
5 ☐ FUTURE MAJOR MEDICAL LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)
( ) -

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE
BARBARA BOLTREK CLAIMS ADMINISTRATOR